PRINTED: 01/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED		
		15G496	B. WI	NG		10/27/	/2015	
			<u> </u>	CTDFFT	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIE	R						
DONA VI	STA PROGRAMS	INC			/ESTDALE CT			
BONA VI	STA PROGRAMS	INC		KOKOMO, IN 46902				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)			DATE		
W 0000								
Bldg. 00								
	This visit was fo	or an extended	W 0	000				
	recertification as	nd state licensure survey.						
		•						
	Dates of Survey	: 10/13, 10/14, 10/15,						
	_							
	10/16, 10/19, 10	0/20, 10/26, and						
	10/27/2015.							
	Facility Number	r: 001010						
	Provider Number: 15G496							
	AIM Number:	100245040						
	Thoso fodorol de	eficiencies also reflect						
	_	accordance with 460						
	IAC 9.							
		this report completed by						
	#15068 on 11/9/15	-						
W 0104	492 440(a)(4)							
VV 0104	483.410(a)(1) GOVERNING BO	NDV						
Bldg. 00		dy must exercise general						
Blag. 00		id operating direction over						
	the facility.	a operating uncestorn ever						
	,	vation and interview, for 2	$W_0$	104	CorrectiveAction(s):		11/26/2015	
		ents (clients #2 and #4)	'' "		Toensure that the governing		11/20/2010	
	•				body will exercise general			
		clients (clients #6 and			policy, budget, andoperating	 		
	, , , , , , , , , , , , , , , , , , ,	ng body failed to exercise			direction over the facility by			
		ion over the facility to			adding doors/closures on			
	ensure their bed	room closets had			clients #2,#4, #6, and #8's			
	doors/closures f	for clients #2, #4, #6, and			bedroom closets, the following	ng		
	#8.				corrective actions will	_		
					beimplemented and followed			
	Findings includ				1.Residential House manage			
	Findings include	<b>○</b> .			will getdoors/closures for clien	เร		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		A. BUILDING B. WING	00	COMPLETED 10/27/2015			
	PROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE			
	During observations on 10/13/15 from 3:45pm until 6:05pm and on 10/14/15 from 6:35am until 8:15am, clients #4, #6, #2, and #8's (shared) bedroom closet doors/closures were missing. On 10/13/15 at 5:20pm, GHS (Group Home Staff) #3 indicated she was unsure how long clients #2, #4, #6, and #8's closet doors/closures were missing. On 10/14/15 at 6:55am, GHS #2 indicated she was unsure how long clients #2, #4, #6, and #8's closet doors/closures had been missing.  On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated she was not aware clients #2, #4, #6, and #8's bedroom closets did not have a closure to the doorway. The DRS indicated no further information was available for review.		#2, #4, #6, and #8's bedroor closets and BonaVista's maintenance department will hang the doors/closures.  2.Residential House mana will do aweekly safety check ensure that all bedroom clos have doors/closures onthem (Appendix A)	ger to ets			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 00 COMPLET  B. WING 10/27/2				D	
	OF PROVIDER OR SUPPLIE			2333 W	ADDRESS, CITY, STATE, ZIP CODE /ESTDALE CT MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) OMPLETION DATE
	interview, for 4 (clients #1, #2, # additional client #8), the facility unimpeded acce toothbrushes, to shampoo, and lie #2, #3, #4, #5, # have documenter restricted access  Findings include  During observat 3:45pm until 6:0 from 6:35am un #3, #4, #5, #6, # throughout the froom door was le was not inside the observation peri #5, #6, #7, and # toothbrush, tooth shampoo, and lie the facility staff, client #3 walked room and asked Staff) #1 for sha liquid shower so file cabinet inside medication room one bottle of sho	ss to the locked othpaste, deodorant, quid soap for clients #1, 6, #7, and #8 who did not d assessments for the to the locked items.	W	0125	CorrectiveAction(s): To ensure all clients have unimpeded access toperson items such as toothpaste, deodorant, shampoo, ect the followingcorrective measure will be implemented:  1. Allclients that reside in the group home will be provided witheir own personalshower book where they have access to the own personal toothbrushes, toothpaste, deodorant, shampoo, and liquisoap. The Residential HouseManag will train all staff working in the home on client rights regardingaccess to and the use of personal hygiene items. Additionally, all staff willbe train on the use of shower boxes for each client. (Appendix B and AppendixC) Records of training will be completed following state trainings and submitted to the Residential Director for administrative oversight	al s s vitth es eir id er e se ined or	/26/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
	15G496	B. WING		10/27/2015	
	PROVIDER OR SUPPLIER STA PROGRAMS INC	2333 W	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT MO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) MPLETION DATE
	of each liquid into a calibrated medication cup and handed the cups to client #3. At 4:28pm, GHS #1 stated clients #1, #2, #3, #4, #5, #6, #7, and #8's toothbrushes, toothpaste, deodorants, shampoo, and liquid bathing soaps were "kept locked up in the office" and did not recall the reason. GHS #1 indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have keys to the secured items. On 10/14/15 at 8:00am, clients #1, #2, #3, #4, #5, #6, #7, and #8 indicated they did not have keys to the medication room and had to ask staff for the use of the locked personal care items.  On 10/15/15 at 3:10pm, client #1's record was reviewed. Client #1's 12/21/14 ISP (Individual Support Plan) and 2014 Risk Assessment did not indicate an identified need to lock personal items such as toothbrushes, toothpastes, deodorants, shampoos, and liquid bathing soaps. Client #1's record did not indicate consent for locked items.  On 10/15/15 at 10:59am, client #2's record was reviewed. Client #2's record was reviewed. Client #2's 6/7/2015 ISP, 6/7/2015 BSP (Behavior Support Plan), and 2015 Risk Assessment did not indicate an identified need to lock personal items such as toothbrushes, toothpastes, deodorants, shampoos, and liquid bathing soaps.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 CO	OMPLETED
	0/27/2015
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
BONA VISTA PROGRAMS INC 2333 WESTDALE CT KOKOMO, IN 46902	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)	DATE
Client #2's record did not indicate	
consent for locked items.	
On 10/15/15 at 1:00pm, client #3's record	
was reviewed. Client #3's 6/7/15 ISP,	
8/2015 BSP, and 2015 Risk Assessment	
did not indicate an identified need to lock	
personal items such as toothbrushes,	
toothpastes, deodorants, shampoos, and	
liquid bathing soaps. Client #3's record	
did not indicate consent for locked items.	
On 10/15/15 at 3:16pm, client #4's record	
was reviewed. Client #4's 1/21/15 ISP,	
8/2015 BSP, and 2014 Risk Assessment	
did not indicate an identified need to lock	
personal items such as toothbrushes,	
toothpastes, deodorants, shampoos, and	
liquid bathing soaps. Client #4's record	
did not indicate consent for locked items.	
On 10/16/15 at 2:45pm, an interview was	
conducted with the Director of	
Residential Services (DRS). The DRS	
indicated she was not aware clients #1,	
#2, #3, #4, #5, #6, #7, and #8's shampoos,	
deodorants, liquid bathing soaps,	
toothbrushes, and toothpastes were kept	
secured. The DRS indicated clients #1,	
#2, #3, #4, #5, #6, #7, and #8 had not given consent for the locked items. The	
DRS indicated no assessments were	
completed for clients #1, #2, #3, #4, #5,	
#6, #7, and #8. No reason was provided	

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	OF CORRECTION  IDENTIFICATION NUMBER:  15G496	X2) MULTIPLE CONSTRUCTION   X3) DATE SURVEY     A. BUILDING   00   COMPLETED     B. WING   10/27/2015				
	PROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W 0129 Bldg. 00	of why locked personal care items were kept locked inside the medication room. The DRS indicated no other information was available for review regarding the locked items.  9-3-2(a)  483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.  Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #4) and 2 additional clients (clients #6 and #7), the facility failed to keep client #2, #4, #6, and #7's personal information confidential by posting each client's full names, work locations, group home addresses, and workshop schedules.  Findings include:  On 10/14/15 from 9:45am until 11:20am, clients #2, #4, #6, and #7 were observed at the facility owned day services.  Visitors, other clients, family members, vendors, and workshop staff were observed to enter and exit the workshop area. At 10:40am, a posted sheet of	W 0129	CorrectiveAction(s): Thefacility must ensure the rights of all clients. Therefor the facility mustprovide each client with the opportunity for personal privacy. The follow correctivemeasures will be implemented:  1. Allconfidential information been removed from documentation that can be seenby others at the Bona Visworkshop. All clients will be addressed on anydocumentat that is in view of others by the HIPPA names. Work locations, group home address and work schedules will not be placed in public view andwill be kept confidential.	has has ion ir ses,		
	paper included a list of clients #2, #4, #6,					

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	ROVIDER OR SUPPLIER STA PROGRAMS I		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	The sheet of pap "Sign In / Sign Coundicated clients names, each clie the area of the worked, and leaving the work the Workshop Sounterviewed and #6, and #7's personal information individual names posted at the factories of people for workshop. The shome staff failed #6, and #7's personal information individual.  9-3-2(a)	#2, #4, #6, and #7's					
W 0149	483.420(d)(1)						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	· ′	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/27/2015	
	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)				DATE	
Bidg. 00	STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 4 of 6 substantiated allegations of staff to client abuse, neglect, and/or mistreatment for 8 of 8		W 0	0149	Finding(s): 1."Thefacility neglected to ensure all clients that reside the group home were	11/26/2015	
	neglect, and/or n	nistreatment for 8 of 8			notsubjected to staff to clien	nt	
	clients (clients #	1, #2, #3, #4, #5, #6, #7,			abuse, neglect, and/or		
	and #8), the facil	lity neglected to ensure			mistreatment."		
	clients #1, #2, #3	3, #4, #5, #6, #7, and #8					
	were not subjected to staff to client abuse, neglect, and/or mistreatment.				CorrectiveAction(s):		
					Toensure to implement and follow written policies and		
	D 1 1				procedures that prohibitmistreatment, neglection	.	
		review and interview,			or abuse of the client the	٠,	
		cted to implement the			following corrective actionw	ill I	
	agency's policy a	and procedure to			be taken:		
	immediately repo	ort allegations of staff to			1.ResidentialHouse manage	er	
	client abuse, neg	lect, and/or mistreatment			will retrain all staff working in t		
	to the administra	tor and to BDDS			home on Bona Vista's Policya		
	(Bureau of Deve	lopmental Disabilities			Procedure for abuse, neglect,		
		ordance with State Law			exploitation. Records of traini will be completedfollowing all	rig	
	ĺ .	arps were kept secured			trainings and be submitted to	the I	
	for clients #6 and				Residential Director for		
	Tor Chemis #0 and	<i>шт</i> г.			administrativeoversight.		
	Događ om magand	marriary and intermitary			(appendix D)		
		review and interview,			2.ResidentialQualified		
		ed clients (clients #1, #2,			Intellectual Disabilities Professional (QIDP) will retrain	n all	
		for 4 additional clients			thestaff working in the home of		
	, , ,	7, and #8), the facility			BDDS reportable incidents and		
	•	te effective corrective			Bona Vista's Policyand Proced		
	action to address the continued client to client physical aggression for clients #1,				for reporting incidents. Record		
					training will be completedfollow		
	#2, #3, #4, #5, #6	6, #7, and #8 for 25 of 82			the training and be submitted the Residential Director for	το	
	reportable incide				administrative oversight.		
					(appendix E)		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			TED	
		15G496	B. W	ING		10/27/2	2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .			ESTDALE CT		
	STA PROGRAMS I		KOKOMO, IN 46902				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION DATE	
TAG		<u> </u>		TAG	•	vice	DATE
IAU	Findings included  1. On 10/14/15 BDDS (Bureau or Disabilities Service reviewed and inclined incidents of substallegations of about mistreatment:  -A 6/30/15 BDD on 6/30/15 at 8:0 home staff left the service was always at the group to take a #2, #3, #4, #5, # name of workshow the group home 8:30am," unlock medication cabin window in the or clients' medication window in the or clients' medicated the age gone and a police were suspended. The report indicated the age gone and a police were suspended. The report indicated the age gone and a police were suspended.	at 12:40pm, the facility's of Developmental ices) reports were cluded the following stantiated staff to client use, neglect, and/or  S report for an incident clue, negroup home "around and drop off [clients #1, 6, #7, and #8] at [the cop] for day services."  And the staff returned to at "approximately ed the front door, net doors were open, a ffice was opened, and the con boxes and clients' ere gone. The report ency credit cards were e report was filed. Staff pending an investigation.		TAG	3.TheResidential Social Sericoordinator will conduct an investigation for allallegations abuse, exploitation, and/or mistreatment. An incident reportthrough the Bureau Developmental Disabilities will filed for all incidentsor allegation for abuse, neglect, exploitation and/or mistreatment. Achecklis attached to each completed investigation to ensure completion ofall required processes and forms. (Appender) The completed investigation will be reviewed by the Residential Directorand the Executive Vice President to ensure all investigations are thoroughlycompleted, recommendation/corrective actions are included, and an incidentreport has been filed.  Finding(s):  1. "Thefacility neglected to implement the agency's policand procedure toimmediately report allegations of staff to client abuse, neglect, and/ormistreatment to the administrator and to the Bureau of DevelopmentalDisabilities Services (BDDS) in accordar with State Law and to ensure sharpswere kept secured for clients #6 and #7."	of  I be ons , st is  dix n	DATE
		lice Report" indicated arred while the night shift			CorrectiveAction(s): Toensure that all sharps are		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       10/27/2015				ETED	
NAME OF	PROVIDER OR SUPPLIE		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT	10/21/	2013
BONA V	ISTA PROGRAMS	INC	KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	"(office) window (sic) was point of still locked and and person was entry and exit. It with \$232.23. Do types of medicar stated he believed A 7/8/15 "Memore Memo" indicated #22: indicated burglarized on money, credit carbone." The Memore of two staff incident, you we investigation. It and state regulat of a drug free In Agency] has a seproviding a safe workplace. Unlasselling, distributed possession, or usubstance or a perior which an emvalid prescription consumption of prohibitedOn drug testin consumption of prohibi	nts to the workshop. The win the back of house of entry. Office door was window was unlocked able to open window to Money box was taken rug box was taken with 7 tion in itOfficer [name] es it was an inside job"  D: Termination/Talking d for Discharged Staff when home was 6/30/15 when drugs, ands were stolen from the emo indicated "You being on shift at the time of the ere suspended pending an an compliance with federal tions and for promotion diana (sic). [Name of trong commitment to alcohol, and drug free twiful manufacturing, ion, dispensing, se of a controlled rescription medication ployee doesn't hold a			kept in a secured place for clients #6 and #7 thefollowing corrective actions will be implemented:  1.ResidentialQualified Intellectual Disabilities Professional (QIDP) will retrain the staff working in the home of clients #6 AND #7's Behavior Support Plans (BSP's) and Human Right Committee (HRC approved restrictions for client and #7. Recordsof training will completed following the training and submitted to the Residential Director for administrative oversight. (Appendix G)	n all n C) #6 I be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE COMPL 10/27/	ETED	
	PROVIDER OR SUPPLIER STA PROGRAMS I		233	33 WE	DDRESS, CITY, STATE, ZIP CODE ESTDALE CT O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	You tested positic categories Mariji Oxymorphone." employment was -A 3/12/15 BDD on 3/10/15 at 8:0 reported that michad woke (sic) [a was upset with holothes in with the bedroom). [Clie aggressive towar reported that [na #7] she was not stried to hit her shohind his back shown." The repowent back to bedreported until 3/3 administrator.  -A 3/12/15 BDD on 3/10/15 at 8:0 reported that michad given [client reward and [namto take (it) back any behaviors."	S report for an incident 100am, indicated "It was dnight [Name of Staff] 1 #1] a bracelet as a 1 the of staff] had threatened 1 if [client #1] displayed The report indicated 1 ded. The incident was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		 JILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/27/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	on 3/10/15 at 8:0 reported that michad [client #3] g bathroom and clefloor when he malso reported that [client #3] to say her giving him streport indicated. The incident was 3/12/15 to the additional to the incident was 3/12/15 to the additional to the incident was 3/12/15 to the additional to the incident was 1/2/15 to the additional to the incident was 1/2/15 in allegation was 1/2/15 in alle	restigation indicated the Substantiated" and ff#22 went to the DRS idential Services) "with a other staff member ame homereports that the staff] was throwing sumers things in the me of midnight staff] #3]saw [client #3] on ees cleaning the urine om floor with no gloves at [name of midnight elient #3] was going to ate on the floor, or he on the toilet like a mitted that she made up his urine off the floor gloves" The icated the midnight staff						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496		JILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/27/	ETED
	PROVIDER OR SUPPLIER STA PROGRAMS I		•	2333 W	DDRESS, CITY, STATE, ZIP CODE ESTDALE CT IO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
	clean clothing in investigation indivestigation indicated staff with	emingling of dirty and side his bedroom. The licated the midnight staff ling clients #1, #2, #3, and #8 "they have to call of respect." The licated the midnight staff the "had given the girls in ets and told them that if ave or they didn't call her was taking the bracelets stigation indicated were "scared" of the ame. The investigation ritten witness statements a staff #22, GHS (Group and GHS #6 which legation of staff abuse lent for clients #1, #3, estigation did not address ons were not immediately vervisor, did not address off continuing to work in lafter the events, and did lates for clients #1, #3, ons. No evidence was liew regarding if the immediately reported.  DS report for an incident soppmindicated client #1 (S #7, "team lead, had on his (own) pants on the clients living at the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/27/	ETED
	PROVIDER OR SUPPLIER STA PROGRAMS I		2333 W	DDRESS, CITY, STATE, ZIP CODE ESTDALE CT IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[Client #1] stated was only there for made her feel un report indicated room "and also whand in his pants indicated GHS # pending an investing indicated "the inthat [GHS #7] has cratched right be watching televis not reported to the the watching televis not reported to the	restigation indicated as statement "(I) wasn't as Scratched myself and to [client #7] and I forgot ble with itIn pants or a Kind of inside. Who here were consumers in hink anyone was a't do it to be socially buring med (medication) told [GHS #1] and said hipset[GHS #1] said she hort [GHS #7]. (I) said [the Residential				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		15G496	B. W	ING		10/27/	/2015
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					ESTDALE CT		
	STA PROGRAMS I	NC		KOKON	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
		e to staff and consumers					
	(clients) at times	likes to give the					
		taff frequent hugs." The					
	investigation "R	ecommendations"					
	indicated "Durin	g the course of the					
	investigation it h	as been determined that					
	[GHS #7] has fa	iled to complete job					
	duties as assigne	ed therefore manager staff					
	is recommending	g termination."					
	_	n included an 4/28/15					
	"Termination/Talking Memo" which						
	_	oril 21, 2015 you were					
		ng your genitals in the					
	_	sumers, which caused the					
		perience emotional					
		niliationduring the					
		restigation it could not be					
	1	u were touching yourself					
		or just scratching yourself					
	as you had stated						
	_	vever, through the course					
	of the investigation	you do not complete job					
	l '						
		ed and do not assist or y tasks requiredThe					
	APS (Adult Prot	_					
	`	ewed the documentation					
		ed with the agency's					
	_	Failure to provide a safe					
	_	all persons served is in					
		' The investigation did					
		the incident was not					
	reported to the a						
	-F == 10 to the t						

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	OF CORRECTION			COMPLETED 10/27/2015	
	PROVIDER OR SUPPLIER STA PROGRAMS I		2333 V	ADDRESS, CITY, STATE, ZIP CODE VESTDALE CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on 4/10/15 at 1:3 was on break at with the break area, at through the outsi area did not followarea to locate clied different area of was located walk workshop and rewith staff. The riemassuspended a #6's BSP (Behaviollow client #6's (Absent without investigation both neglected to impensure client #6's BDDS (Bureau or Disabilities Serviewed and incidents of substallegations of abmistreatment:  -An 4/28/15 BDI on 4/28/15 at 7:3 "kicked" client #7'ran to kitchen at threatened others.	at 12:40pm, the facility's			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	ľ í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/27/	ETED
	PROVIDER OR SUPPLIER		•	2333 W	DDRESS, CITY, STATE, ZIP CODE ESTDALE CT IO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) #7's hands.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	3:45pm until 6:0 #4, #5, #6, #7, at the group home. administered me shelf inside the r locked box conta sharps of knives, coring utensil, ra sharp objects. A retrieved a knife GHS #1 stated th "because of" clie facility staff had At 5:00pm, clier cutting tomatoes took the knife fre finished cutting to since the sharp ob #4 laid the knife, G phone in her poo #4 laid the knife walked into the r on her cell phone unsecured on the client #7 walked his hands at the l clients #1, #2, #4 seated at the dint	son on 10/13/15 from 5pm, clients #1, #2, #3, and #8 were observed at At 4:00pm, GHS #1 dications and on the nedication room was a mining locked/secured forks, can opener, apple azors, and other metal at 4:20pm, GHS #1 GHS #3 requested. The locked sharps were ent #7's behaviors and the to "keep sharps locked." at #6 was in the kitchen with a knife, GHS #4 om client #6, and the tomatoes. At the began to cut lettuce the HS #4's personal cell ket began to ring, GHS down on the counter, medication room talking the counter. At 5:40pm, into the kitchen to wash witchen sink. At 5:50pm, at 1, #5, #6, #7, and #8 were and room table. Two (2) cured on top of the					

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	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL	
		15G496	B. WI		<u></u>	10/27	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ESTDALE CT		
BONA V	STA PROGRAMS I	NC		KOKOM	IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE	
TAG		m 9:45am until 11:20am,		TAG	DLI ICILICI )		DATE
		conducted at the facility					
	owned day servi	·					
	1	od client #7 sat in a					
	_	six other clients and one					
		and a pair of unsecured					
	metal scissors la	-					
	On 10/16/15 at 2	2:45pm, an interview was					
conducted with the Director of							
Residential Services (DRS). The DRS							
stated client #7 "required locked sharps"							
	to be secured.						
	0 10/10/15 41	0.45					
		0:45am, client #6's wed. Client #6's 7/25/15					
		BSP indicated he needed					
		red sharps "at all times."					
		indicated he required					
	_	ir hours a day/seven days					
	a week) staff sup	-					
	On 10/19/15 at 1	0:30am, client #7's					
	record was revie	wed. Client #7's 5/16/15					
	ISP and 9/25/15	BSP indicated client #7					
	"required" locke	d sharps due to prior					
	attempts of hurti	ng other people with					
	knives during wa	aking and sleeping hours.					
	•	indicated he required					
		ir hours a day/seven days					
	a week) staff sup	pervision.					
	On 10/16/15 + 3	1.45 mm on interests					
		2:45pm, an interview was					
	conducted with t	the Director of					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	СОМ	e survey pleted 7/2015
	PROVIDER OR SUPPLIER		2333 W	ADDRESS, CITY, STATE, ZIP CO /ESTDALE CT MO, IN 46902	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	indicated clients secured locked k DRS indicated be a documented be sharps should be "at all times excedirectly supervised."  3. On 10/14/15 BDDS (Bureau of Disabilities Service) and incomplete the secure of the	ices (DRS). The DRS #6 and #7 needed chives and sharps. The oth clients #6 and #7 had chavioral history that e kept secured and locked cept" when staff were ching the use.  at 12:40pm, the facility's of Developmental cices) reports were cluded the following at to client physical				
	5/6/15 at 10:45a	S report for an incident on m indicated client #2 was nidentified client at the shoulder.				
	on 4/12/15 at 5:4 had purchased a "wanted [client # refused to give h	DS report for an incident #0pm indicated client #2 new item, client #4 #2's] item," client #2 ter item to client #4, and int #2 on the arm.				
	on 8/15/15 at 12 #3 and #6 were	DS report for an incident :55pm indicated clients carrying in groceries shoved" client #6				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 27/2015
	PROVIDER OR SUPPLIEF		2333 W	ADDRESS, CITY, STATE, ZIP CO /ESTDALE CT MO, IN 46902	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	_	t doorway which caused scraping his right knee se.				
	on 6/14/15 at 6:0 "walked through	OS report for an incident Opm indicated client #2 the doorway" and client No injury was noted.				
	6/4/15 at 1:00pm "came up from b workshop and "v	S report for an incident on indicated client #3 behind a female" at was inappropriate" as around the person.				
	on 4/12/15 at 6:0 was in the kitcher client #5 twice to spoon, client #5	DS report for an incident 00pm indicated client #3 en for a drink, asked o move so he could get a did not move "fast ent #3 "hit her in the				
	on 10/6/15 at 6:4 "reported" that c	DS report for an incident 45pm indicated client #2 lient #4 "punched her on ." No injuries were				
	on 4/30/15 at 9:0 "tried to hug the	DS report for an incident 00am indicated client #4 agency nurse," client #4 rom hugging, and client				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  B. WING			COMPLETED 10/27/2015		
	ROVIDER OR SUPPLIER		2333 W	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	-An 4/28/15 BDI on 4/28/15 at 6:0 was "mad, yellin client #4 in the rie eating at the table red" area on his beauting and on left side." Nowas "crying and on left side." Nowas "cry	S report for an incident pm indicated client #8 said" client #4 "hit her injury noted.  report for an incident on indicated client #7 was on and kicked client #6 To injury.  report for an incident on indicated client #7 was cked client #8 in her left  S report for an incident pm indicated client #7 ehaviors" at workshop, solice expressing suicidal sponded, client #7 ran			

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	PROVIDER OR SUPPLIER STA PROGRAMS I		2333 \	FADDRESS, CITY, STATE, ZIP CO WESTDALE CT DMO, IN 46902	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	-An 8/5/15 BDD on 8/4/15 at 3:30 "yelled, kicked, a in the left (L) leg television (TV).  -A 8/5/15 BDDS 8/4/15 at 4:00pm "agitated," told of "kicked" client #4 in "hit" client #4 in "-A 5/27/15 BDD on 5/27/15 at 8:0 was "upset all da hit [client #3] on #8] in the leg, an #7] made scratch spoon." The rep was taken to the Residential Man windshield in the -A 5/25/15 BDD on 5/24/15 at 2:0	S report for an incident and scratched" client #2 while watching  The report for an incident on an indicated client #7 was alient #8 to "be quiet,"  2 in the left leg, and the head.  S report for an incident and indicated client #7 was alient #7 was alient #8 to "be quiet,"  2 in the left leg, and the head.  S report for an incident and indicated client #7 was alient #7 was ali	TAG		PROPRIATE	DATE
	on 5/23/15 at 2:4 was "yelling" an	S report for an incident 5pm indicated client #7 d sitting on the sofa, " client #8's left lower				

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	OF CORRECTION	IDENTIFICATION NUMBER:	l í	ILTIPLE COI ILDING	NSTRUCTION 00	COMPL	
1111212111	or condition	15G496	B. WI		00	10/27	
			<del></del>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ESTDALE CT		
BONA VI	STA PROGRAMS	INC		KOKOM	O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		OS report for an incident 20pm indicated client #7					
		telf in the kitchen,					
		nd head," called client #4					
		ent #4 hit client #7 on					
		ad. Client #7 had a					
	bruised right arn						
	-A 5/12/15 BDD	OS report for an incident					
	on 5/11/15 at 1:5	58pm indicated client #7					
was "arguing" with client #8, kicked							
client #8 in the shin, hit client #8 in the							
	stomach, and "sa	at" on client #8.					
	4 4/00/15 DD	D.C					
		DS report for an incident					
		30am indicated client #7					
		#8, "shoved" client #6, and grabbed a knife,"					
		s with the knife, and staff					
		terventions to remove the					
	knife from clien						
		v ii y b marab.					
	-An 4/28/15 BD	DS report for an incident					
	on 4/27/15 at 4:3	30pm indicated client #7					
	kicked client #8	, client #7 "tried" to					
	apologize, client	#8 refused client #7's					
	apology, and cli	ent #7 grabbed client #8's					
	~	cked her. No injuries					
	were noted.						
	An 4/10/15 DD	DS raport for an incident					
		DS report for an incident 50am indicated client #7					
		e kitchen, became "mad					
		5 in the left shoulder and					
	and mit chem #.	om me ien shouldel allu					

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AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/27/2015	
	PROVIDER OR SUPPLIER		2333 W	ADDRESS, CITY, STATE, ZIP CODE /ESTDALE CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		#5 "twice into the wall." ated client #5 had "red noulder.			
	on 4/4/15 at 5:15 "talked" with cli	OS report for an incident 5pm indicated client #7 ent #4, client #4 kicked eft leg. No injuries			
	on 4/13/15 at 8:3 were "arguing" a "job," client #8 v	DS report for an incident 80am indicated clients at workshop about a was hit by the other client and on the right arm. No ted.			
	at 4:00pm, interview with the DRS (E Services). The I corrective measure and none were a clients #1, #2, #2 continued to be client physical a indicated the fact policy and process abuse, neglect, a DRS indicated the immediately repland/or to BDDS	2:45pm and on 10/19/15 views were conducted Director of Residential DRS indicated no ares were documented vailable for review after B, #4, #5, #6, #7, and #8 involved in client to ggression. The DRS illity followed the BDDS redure for allegations of and/or mistreatment. The are facility did not ort to the administrator in accordance with State investigate client #1 and			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		l í	UILDING	nstruction 00	(X3) DATE COMPL 10/27/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	clients #1, #2, #3	egarding GHS #7 and for 3, #4, #5, #6, #7, and #8's ding staff neglect and/or							
	completed of the Developmental I and Guidelines." procedure indica and Mistreatment policy of the continuity of the cont								
	of the facility's u procedures for A Exploitation indi Exploitation" ne	:00pm, a record review and ated policy and abuse, Neglect, icated "Abuse, Neglect, glect was defined as de goods and/or services							

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	ROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
W 0157 Bldg. 00	necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment" The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law.  9-3-2(a)  483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to complete effective corrective action to address the continued client to client physical aggression for clients #1, #2, #3, #4, #5, #6, #7, and #8 for 25 of 82 reportable incidents reviewed.  Findings include:	W 0157	CorrectiveAction(s): Toensure when an alleged violation is verified that appropriate corrective action taken the following will be implemented and followed: 1.TheSocial Service Coordinator completes all investigations of client to clientaggression. When an alleged violation is verified the Social ServiceCoordinator will contact the Residential Qualification in the contact the Residential Qualification in the contact the Residential Qualification is verified the social ServiceCoordinator will contact the Residential Qualification in the contact the c	ed			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		l í	JILDING	onstruction 00	(X3) DATE : COMPL 10/27/	ETED			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
	3:45pm until 6:0 #4, #5, #6, #7, at the group home. administered me shelf inside the r locked box conta sharps of knives, coring utensil, ra sharp objects. A retrieved a knife GHS #1 stated th "because of" clie facility staff had At 5:00pm, clier cutting tomatoes took the knife fr finished cutting f 5:00pm, GHS #4 with the knife, G phone in her poo #4 laid the knife walked into the r on her cell phone unsecured on the client #7 walked his hands at the l clients #1, #2, #4 seated at the din knives laid unsec kitchen counter.	fon on 10/13/15 from 5pm, clients #1, #2, #3, and #8 were observed at At 4:00pm, GHS #1 dications and on the medication room was a mining locked/secured forks, can opener, apple azors, and other metal at 4:20pm, GHS #1 GHS #3 requested. The locked sharps were ent #7's behaviors and the to "keep sharps locked." at #6 was in the kitchen with a knife, GHS #4 form client #6, and the tomatoes. At the began to cut lettuce for the sharps locked with the sharps locked. The knife was left to counter, medication room talking for the knife was left to counter. At 5:40pm, into the kitchen to wash witchen sink. At 5:50pm, for the knife was left to counter. The knife was left to counter. At 5:40pm, into the kitchen to wash witchen sink. At 5:50pm, for the knife was left. Two (2) cured on top of the			and submit corrective action for the violation. TheResidential Director and the Executive Violation President reviews all completed investigations and vensure that appropriate correction has been submitted for additional administrative oversight.	ce vill			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G  00	COM	TE SURVEY PLETED 27/2015		
	PROVIDER OR SUPPLIER STA PROGRAMS I		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
	owned day servious observation period classroom with s	od client #7 sat in a ix other clients and one nd a pair of unsecured						
	conducted with t Residential Serv	:45pm, an interview was he Director of ices (DRS). The DRS required locked sharps"						
	On 10/19/15 at 10:45am, client #6's record was reviewed. Client #6's 7/25/15 ISP and 7/25/15 BSP indicated he needed locked and secured sharps "at all times." Client #6's plans indicated he required 24/7 (twenty-four hours a day/seven days a week) staff supervision.							
	record was revie ISP and 9/25/15 "required" locked attempts of hurting was knives during was Client #7's plans	0:30am, client #7's wed. Client #7's 5/16/15 BSP indicated client #7 d sharps due to prior ng other people with aking and sleeping hours. indicated he required r hours a day/seven days servision.						
	conducted with t	:45pm, an interview was he Director of ices (DRS). The DRS						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	ILTIPLE COI ILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G496	B. WII		00	10/27/	
NAME OF E	PROVIDER OR SUPPLIER	)		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					ESTDALE CT		
	STA PROGRAMS				IO, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	•	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
		#6 and #7 needed					
	secured locked k	knives and sharps. The					
		ooth clients #6 and #7 had					
	a documented be	ehavioral history that					
	sharps should be	kept secured and locked					
	"at all times exc	ept" when staff were					
	directly supervis	sing the use.					
	On 10/14/15 of 1	12:40pm, the facility's					
		of Developmental					
	,	vices) reports were					
		cluded the following					
		nt to client physical					
	aggression:	nt to enemt physical					
	aggression.						
	For client #2:						
	-A 5/7/15 BDDS	S report for an incident on					
	5/6/15 at 10:45a	m, indicated client #2					
	was hit by anoth	er unidentified client at					
	the workshop or	her shoulder.					
	- Δn 4/13/15 RD	DS report for an incident					
		40pm indicated client #2					
		new item, client #4					
	-	#2's] item," client #2					
	_	ner item to client #4, and					
		nt #2 on the arm.					
	For client #3:						
		DS report for an incident					
		:55pm indicated clients					
		carrying in groceries					
		shoved" client #6					
	through the fron	t doorway which caused					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
THIE TELLY	or condition	15G496	B. W		00	10/27	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R		1	ESTDALE CT		
BONA VI	STA PROGRAMS	INC		KOKOM	IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and a small brui	scraping his right knee					
	and a sman orun	5C.					
	-A 6/15/15 BDD	OS report for an incident					
		Opm indicated client #2					
	"walked through	the doorway" and client					
	#3 "pushed her.'	No injury was noted.					
		S report for an incident on					
	•	n indicated client #3					
	_	oehind a female" at was inappropriate"					
	_	ns around the person.					
	wrapping ins arr	ns around the person.					
	-An 4/13/15 BD	DS report for an incident					
		Opm indicated client #3					
		en for a drink, asked					
	client #5 twice to	o move so he could get a					
	spoon, client #5	did not move "fast					
	enough," and cli	ent #3 "hit her in the					
	stomach."						
	D 1:						
	For client #4:	DC mamout for an in aid and					
		DS report for an incident					
		45pm indicated client #2 lient #4 "punched her on					
	_	." No injuries were					
	noted.	. No injuries were					
	110104.						
	-An 4/30/15 BD	DS report for an incident					
	on 4/30/15 at 9:0	00am indicated client #4					
	"tried to hug the	agency nurse," client #4					
		rom hugging, and client					
	#7 shoved client	#4 away from the nurse.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILD		00	(X3) DATE : COMPL			
		15G496	B. WING		<u>00                                   </u>	10/27/		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	on 4/28/15 at 6:0 was "mad, yelling client #4 in the reating at the table red" area on his  -An 4/5/15 BDD	DS report for an incident 20pm indicated client #7 ng, ran, then kicked" ight hip while he was le. Client #4 had a "light buttocks.  DS report for an incident 20pm indicated client #8						
	was "crying and said" client #4 "hit her on left side." No injury noted.							
	For client #7:  -A 9/8/15 BDDS report for an incident on 9/7/15 at 6:20pm indicated client #7 was watching television and kicked client #6 in "both legs." No injury.  -A 9/8/15 BDDS report for an incident on 9/7/15 at 6:00pm indicated client #7 was "agitated" and kicked client #8 in her left lower leg.							
	on 8/5/15 at 5:45 had "increased be client #7 called performance through threats, police reaway from police."	OS report for an incident from indicated client #7 behaviors" at workshop, police expressing suicidal esponded, client #7 ran e, client #7 was taken to the local						
	-An 8/5/15 BDD	S report for an incident						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G496	B. W	ING	<u> </u>	10/27/	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ESTDALE CT		
	STA PROGRAMS I			<u> </u>	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	on 8/4/15 at 3:30	pm indicated client #7					
	"yelled, kicked,	and scratched" client #2					
	in the left (L) leg	g while watching					
	television (TV).						
	-Δn 8/5/15 RDD	S report for an incident					
		pm indicated client #7					
		old client #8 to "be					
		client #2 in the left leg,					
	and "hit" client #	•					
		S report for an incident					
		00am indicated client #7					
	_	ytargeted housemates,					
		right arm, kicked [client					
	_	nd later in the day [client					
	=	nes on his stomach with a					
		ort indicated client #7					
	was taken to the	-					
	windshield in the	ager and he punched her					
	willusilleld ill till	c cai.					
	-A 5/25/15 BDD	S report for an incident					
	on 5/24/15 at 2:0	00pm indicated client #7					
	was "agitated" a	nd hit client #6 on the					
	right knee.						
	_Δ 5/23/15 RDD	S report for an incident					
		45pm indicated client #7					
		d sitting on the sofa,					
		l" client #8's left lower					
	leg.	. Chefit #05 fort fower					
	<i>5</i> .						
	-A 5/12/15 BDD	S report for an incident					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL		
11112 12111	or condition	15G496	B. WI		00	10/27	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ESTDALE CT		
BONA VI	STA PROGRAMS	INC		KOKOM	IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		20pm indicated client #7 elf in the kitchen,					
		nd head," called client #4					
	• •	ent #4 hit client #7 on					
		ad. Client #7 had a					
	bruised right arn						
	-A 5/12/15 BDD	OS report for an incident					
	on 5/11/15 at 1::	58pm indicated client #7					
	was "arguing" w	rith client #8, kicked					
	client #8 in the s	shin, hit client #8 in the					
	stomach, and "sa	at" on client #8.					
		DS report for an incident					
		30am indicated client #7					
		#8, "shoved" client #6,					
		and grabbed a knife,"					
		s with the knife, and staff terventions to remove the					
	knife from clien						
	Kinic from chen	t #7 S Harias.					
	-An 4/28/15 BD	DS report for an incident					
		30pm indicated client #7					
	kicked client #8	, client #7 "tried" to					
	apologize, client	#8 refused client #7's					
	apology, and cli	ent #7 grabbed client #8's					
	right arm and ki	cked her. No injuries					
	were noted.						
	4/10/15 55	DG 16 11					
		DS report for an incident					
		50am indicated client #7					
		e kitchen, became "mad					
		5 in the left shoulder and #5 "twice into the wall."					
	snoved" client	+3 twice into the wall."					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MU A. BUI B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL 10/27/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	The report indica marks" on her sh	ated client #5 had "red coulder.							
	on 4/4/15 at 5:15 "talked" with clie	S report for an incident ipm indicated client #7 ent #4, client #4 kicked eft leg. No injuries							
	For client #8: -An 4/13/15 BDDS report for an incident on 4/13/15 at 8:30am indicated clients were "arguing" at workshop about a "job," client #8 was hit by the other client with an open hand on the right arm. No injuries were noted.								
	at 4:00pm, interview with the DRS (D Services). The I corrective measure and/or available #1, #2, #3, #4, #5	for review after clients 5, #6, #7, and #8 nvolved in client to							
	9-3-2(a)								
W 0249 Bldg. 00	formulated a client	EMENTATION erdisciplinary team has t's individual program plan, eceive a continuous active							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G496	B. WING 10/27/20			2015	
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			/ESTDALE CT		
RONΔ VI	STA PROGRAMS	INC			MO, IN 46902		
DOINA VI	- TAT KOGKAWS		KUKUK				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n consisting of needed					
		services in sufficient					
	number and frequency to support the achievement of the objectives identified in the individual program plan.  Based on observation, record review, and interview, for 4 of 4 sampled clients						
			l w (	249	CorrectiveAction(s): Toensu	re	11/26/2015
				-	that all clients receive		
	· ·	43, and #4) and 4			continuous active treatment		
					programmingconsistent of		
		s (clients #5, #6, #7, and			needed interventions and		
		failed to implement			services in sufficient numbe		
		3, #4, #5, #6, #7, and #8's			andfrequency to support the		
	ISPs (Individual	Support Plans) and			achievement of the objective identified in the	es	
	BSPs (Behavior	Support Plans), failed to			individualprogram plan, the		
	implement ISP of	objectives, and failed to			following corrective actions		
	allow clients to	demonstrate their skills			will be implemented		
	when opportunit	ies existed.			andfollowed:		
	11				1.TheResidential Qualified		
	Findings include	<u>.</u>			Intellectual Disability Profession	onal	
	i mamgs merade	··			(QIDP) willimplement Bicycle	_	
	1 5 1	10/12/15 6			safety risk plans for Client #1		
		vation on 10/13/15 from			client #6 and willinclude safety equipment required to wear a		
	_	95pm, clients #1, #2, #3,			steps to follow for	iu	
		he group home. From			monitoring.Pedestrian safety		
	4:30pm until 4:5	55pm, client #1 (without			checklist will be revised for clie	ent	
	a helmet) and cli	ient #6 wore a helmet and			#1 and #6. InformalBicycle Sa	•	
	rode their indivi	dual three wheel bicycles			program goals will be added for	or	
	separated by the	distance of a city block,			client #1 and client #6.		
	1 ^ -	oup Home Staff) #1			TheResidential QIDP will train staff that work in the home on		
		eross the road on the			plans whenrevised. All records		
		walking with clients #2			training will be completed	5 01	
		own the sidewalk.			following the trainings andbe		
	_				submitted to the Residential		
		6 rode down the middle			Director for administrative		
	of the street and turned their three wheel				oversight. (AppendixH)		
	_	by turning on the			2.TheResidential QIDP will re-train all staff that work in th	۵	
	blacktop and inte	o the lanes of oncoming			group home on all 8client's IS		
	traffic. One end	of the road was a dead			BSP's, all Human Right	. 3,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		15G496	B. WING			10/27/2	015
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				/ESTDALE CT		
DONA M	CTA DDOCDAMC I	NC					
BOINA VI	STA PROGRAMS I	NC		KUKUK	ЛО, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	end and the other	r end of the road merged			Committee (HRC) approved		
	with a main road	for the city. During the			restrictionsfor the entire home,		
		od trucks and cars were			and Individual program goals.	All	
	_				records of trainingswill be		
		g and exiting the road.			completed following the trainin	gs	
		ras observed. GHS #1			and submitted to the  ResidentialDirector for		
		onto client #2's hand and			administrative oversight.		
	while talking wit	th client #3. GHS #1			(Appendix I)		
	stopped walking	in front of the group			3.TheResidential House		
		while clients #1 and #6			manager will train all staff that		
	]	their bicycles a city			work in the home on clientRigh		
		•			(offering choices and supportir	ng	
	block to 1 1/2 block	ocks away.			independence). All records of		
					trainingswill be completed		
	During observati	on on 10/13/15 at			following trainings and submitt	ed	
	5:50pm, clients #	#1, #2, #4, #5, #6, #7,			to the Residential Directorfor		
	_	aking verbally and sat			administrative oversight.		
	_	ng room table for supper.			(Appendix J)		
		til 6:05pm, GHS #3,			_ <u>W249</u> Finding(s): 1."Toprotect resident priva	<u>.,,  </u>	
	_	• •			and confidentiality."	cy	
		IS #5 began to serve			CorrectiveAction(s): Toensur	.	
	clients #1, #2, #4	1, #5, #6, #7, and #8 their			onsite monitoring will be don		
	supper meal. GI	HS #3 stood by the			to protect resident privacy		
	prefilled covered	l serving bowls and			andconfidentiality.		
	1 ^	hich she placed on the			1.The Vice President and th	ne	
		e. GHS #3 uncovered			Directorof Bona Vista's Day		
	_				Service Programs will do a		
		ne and GHS #3 passed			weekly check of the Sky		
		client seated around the			programclassrooms to ensur	·e	
	table. Client #8	refused to have a bun on			that all confidential resident		
	her plate. GHS #	#3 stated "You must have			information is protectedand		
	a bun." Client #8	8 refused the bun three			not in sight. Any breech of		
		S #3 picked up a bun			protected information that is		
		ouns she was holding,			found will bereported		
		•			immediately to the Residentia		
		ovement towards client			Director and a meeting will be	e	
		#8 grabbed GHS #3's			held todiscuss further		
	wrist, and pushed	d GHS #3's hand and bun			resolutions to protect the		
	away. Client #8	stated loudly "I ain't			resident's confidential		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MULTI A. BUILDI B. WING	PLE CONSTRUCTION ING 00	(X3) DATE SUI  COMPLETI  10/27/20	ED	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  I SC IDENTIFYING INFORMATION)	ID PRE	FIX PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	CCTION ULD BE PROPRIATE	(X5) OMPLETION DATE	
TAG	taking no bun." and over the din #4 and GHS #5 #4, #5, #6, #7, a clients got each did not speak to #7, and #8. GHS isn't a Hamburge #3 indicated to of for Hamburger of Client #8 indicate not eating a Bun on her plate. Fro GHS #3 filled of #7's plates, and a client #8's plate stated "I'm not s did not ask each their plates, pour added condiment ketchup to the p  On 10/16/15 at 2 conducted with Residential Serv indicated clients #7, and #8's obje implemented wh The DRS indicate #5, #6, #7, and # encouraged to ex The DRS indicate their skills to asset	2:45pm, an interview was	TA	information.  W249 Finding(s):  1.Onsitemonitoring sh done to ensure ISP's, B client objectives areimpl The monitoring should b frequent than weekly.  CorrectiveAction(s):  Onsitemonitoring should to ensure ISP's, BSP's, objectives areimplement  1.TheResidential House Manager and the Reside Lead DSP will review programgoals to ensure being completed and implemented, as per the fourtimes a week. This documentedand the Qualintellectual Disability Pro (QIDP) will review theda weekly. If formal program goals are not being implemented as per theISP or are not completed the Qualified Intellectual DisabilityPro will be retrained all Residented Intellectual House Manager and The Residential House Manager and The Residential House Supervisoryresponsibilities home seven days a week will monitor Residential ensure that the persons BSP's are being implemented and followed accordingly observe that the BSP's a being followed and mimplemented and followed and mimplem	ould be SP's, and emented. e more  I be done and client ted. se ential they are  IISP, will be alified ofessional ta mming emented being fessional dential ome in goals. se ential es in the ek. They osp's to served ented if they are not mented	DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	JILDING	00	COMPL	
		15G496	B. Wl	ING		10/27/	/2015
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER				ESTDALE CT		
	STA PROGRAMS I	-			лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		<u> </u>		TAG	DisabilitiesProfessional (QIDP	`	DATE
	indicated clients #1, #2, #4, #5, #6, #7,				will be notified and all Residen	•	
	and #8 were verbal and had the skills to fill their own plates, add their own				staff that work in thehome will	be	
	_				retrained on the BSP's.		
	condiments, and pour their own drinks						
	during dining.						
	2. During obser	vation on 10/13/15 from					
	3:45pm until 6:0	5pm, clients #1, #2, #3,					
	#4, #5, #6, #7, a	nd #8 were observed at					
	the group home.	At 4:00pm, GHS #1					
	administered me	dications and on the					
	shelf inside the r	nedication room was a					
	locked box conta	aining locked/secured					
	sharps of knives.	, forks, can opener, apple					
	_	azors, and other metal					
	sharp objects. A	t 4:20pm, GHS #1					
		GHS #3 requested.					
		ne locked sharps were					
		ent #7's behaviors and the					
		to "keep sharps locked."					
	1	nt #6 was in the kitchen					
	_	with a knife, GHS #4					
	_	om client #6, and					
		the tomatoes. At					
		began to cut lettuce					
	_	GHS #4's personal cell					
		eket began to ring, GHS					
	1 ^ ^	down on the counter,					
		medication room talking					
		e. The knife was left					
	1	e counter. At 5:40pm,					
		into the kitchen to wash					
		kitchen sink. At 5:50pm,					
		4, #5, #6, #7, and #8 were					
	J. J	.,,,, and were					

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G496	A. BUILDING B. WING	00	COMPLETED 10/27/2015
	ROVIDER OR SUPPLIER		2333 W	ADDRESS, CITY, STATE, ZIP CODE	
	STA PROGRAMS I		KOKON	1O, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	knives laid unsec kitchen counter.	ng room table. Two (2) cured on top of the			
	observation was owned day service observation period classroom with s	od client #7 sat in a ix other clients and one nd a pair of unsecured			
	conducted with the Residential Service	:45pm, an interview was the Director of tices (DRS). The DRS required locked sharps"			
	was reviewed. C (Individual Supp Assessment indic (twenty-four hou week) staff super indicated objection	:10pm, client #1's record Client #1's 12/21/14 ISP ort Plan) and 2014 Risk cated she required 24/7 rs a day/seven days a rvision. Client #1's ISP wes to socialize outside omplete physical therapy ate a chore around the to speak clearly.			
	record was review 6/7/2015 ISP, 6/7 Support Plan), ar	7/2015 BSP (Behavior			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MULTIPLE  A. BUILDING  B. WING	construction 00	(X3) DATE COMPI 10/27			
	ROVIDER OR SUPPLIER STA PROGRAMS I		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	during meals, to saw in a picture, fingernails, to propose the fingernails, to propose and to identify the name. Client #2 required 24/7 (two day/seven days as the complete days as the complete activities activities, to cooper and the complete daily activities, to cooper a day/seven supervision.  On 10/15/15 at 3 was reviewed. On 10/15/15 at 1 was reviewed.	actice spelling first own water temperature, he letters in her first 's plans indicated she wenty-four hours a he week) staff supervision.  :00pm, client #3's record Client #3's 6/7/15 ISP, hd 2015 Risk cated objectives to work out losing focus, to es, to clean his bedroom, y chore, to participate in k a side dish, and to Client #3's plans hired 24/7 (twenty-four n days a week) staff  :16pm, client #4's record Client #4's 1/21/15 ISP, he 2014 Risk Assessment the skills to choose his e, and pour his drinks. indicated he required ar hours a day/seven days						
I	10001u was 10110	wed. Chefit π0 5 //23/13						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MUL <sup>2</sup> A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPL 10/27/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
	to increase pedershow ID card with #6's record indicated share #6's ISP, BSP, a indicated he required hours a day/seve supervision.  On 10/19/15 at 1 record was revied ISP and 9/25/15 "required" locked attempts of hurting knives during with Client #7's plans 24/7 (twenty-four a week) staff supervision.  On 10/16/15 at 2 conducted with the Residential Servindicated clients secured locked known process producted with the Residential Servindicated by a documented by sharps should be sharps should	2:45pm, an interview was the Director of ices (DRS). The DRS #6 and #7 needed thicks and sharps. The oth clients #6 and #7 had behavioral history that the kept secured and locked ept" when staff were						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15G496	B. WI	NG		10/27/	2015
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ESTDALE CT		
DONA M	STA PROGRAMS I	NC			MO, IN 46902		
DOINA VI	3 IA PROGRAINS I	NC .		KUKUK	WO, IN 40902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0331	483.460(c)						
	NURSING SERVI						
Bldg. 00		rovide clients with nursing					
		ance with their needs.		221	Finding (a)		11/06/0015
		ation, record review, and	$W^0$	331	Finding(s):   1."Thefacility's nursing sta	££	11/26/2015
	-	of 4 sampled clients			failed to develop a client	"	
	(client #4) who h	nad an open wound and a			specific protocol forclient #4	's	
	history of MRSA	(Methicillin Resistant			MRSA and open skin area."		
	Staphylococcus	Aureus, a skin infection),			, , , , , , , , , , , , , , , , , , , ,		
	the facility's nurs	sing staff failed to		CorrectiveAction(s):			
	_	specific protocol for			Toprovide clients with nursir	ng	
	•	A and open skin area.			services in accordance with		
		*			their needs thefollowing		
	_	d for 1 additional client			corrective actions will be		
	,	ived in the group home,			implemented:		
	to ensure client #	48's topical medication			1.TheResidential Nurse will	lon	
	was available at	the group home on			revise client #4's MRSA risk plan specifying theprotocol for client		
	10/12/15 and 10/	/13/15.			#4's MRSA and open skin area		
					All staff working in thegroup		
	Findings include				home will be trained on the		
	1 111411185 11141444	•			revised risk plan. Records of		
	1 Duning alagam	vation on 10/13/15 from			training willbe completed follow	•	
	_				the training and submitted to the	ne	
	-	5pm, client #4 walked			Residential Directorfor		
	throughout the g	•			administrative oversight. (Appendix K)		
	bandage/covering	g of his lower left leg			2.TheResidential House		
	was observed, ar	nd the red shiny skin area			manager will train all staff worl	kina	
	extended from be	elow client #4's left knee			in the home	5	
	to above his ank	le covering the left lower			onhandwashing/Universal		
		GHS #1 administered			Precautions and Infectious		
	client #4's medic				Disease Control. Records		
		thed and rubbed his			oftraining will be completed		
					following the trainings and submitted to theResidential		
		ered shiny red skin area			Director for administrative		
		No hand washing was			oversight.		
		g the medication			3.TheResidential Qualified		
	administration ti	me client #4's lower left			Intellectual Disabilities		
	leg was not asses	ssed, treated, and client			Professional (QIDP) will traina	II	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15G496	B. W			10/27/	2015
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
501414	OTA DDOODANO	110			ESTDALE CT		
BONA VI	STA PROGRAMS	INC		KOKON	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup> DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	staff working in the home on a	II	DATE
	#4 was not disco				the clients' informal handwash		
	_	ng the area. From			goals. Recordsof training will b	•	
	-	70pm, client #4 scratched			completed following the trainin		
		pen skin area to left			and submitted to theresidentia	I	
	_	at #4 walked into/out of			Director for administrative oversight (Appendix L).		
	_	n, television room,			oversignt (Appendix E).		
	_	oors, went inside/outside,					
		hing was observed. At			Finding(s):		
	-	4 assisted to set the			b. "Thefacility's nursing staff	f	
	_	le with silverware			failed to ensure client #8's topical medication		
	_	s his hands. At 5:50pm,			wasavailable at the group		
	client #4 passed	bowls from client to			home on 10/12/15 and		
	client, handled s	erving spoons, and fed			10/13/15."		
	himself a hambu	rger on a bun and french			-		
	fries without wa	shing his hands. From			Commontive Action (a)		
	5:50pm until 6:0	5pm, client #4 was			CorrectiveAction(s): Toprovide clients with nursir	na	
	observed to bend	d over his chair at the			services in accordance with	.8	
	table to reach un	der his pant hem to			their needs thefollowing		
	scratch and rub l	nis red shiny skin area on			corrective actions will be		
	his lower left leg	g then handle food items			implemented:		
	without washing	his hands.			1.TheResidential Nurse will train all staff working in the hole	me	
					on the followingprocedure for	ilic	
	On 10/14/15 fro:	m 6:35am until 8:15am,			reordering medications. On		
	client #4 was ob	served at the group			Wednesday's the midnight sta	ff	
	home. At 6:55a	m, GHS #2 administered			_	liet	
	client #4's oral n	nedications. At 6:55am,					
					task, the Residential Lead DSI		
					will review this list onThursday		
		_				iew	
	couple of months." GHS #2 stated the				ensure additional administrativ	⁄e	
	•				oversight. Records oftraining v	vill	
		ourths around" and			be completed following the		
		hes (10") around left side			_		
	client #4's oral n GHS #2 asked c pant leg to show #4 pulled up his client #4's skin a couple of month area on client #4 the area "three fo	hedications. At 6:55am, lient #4 to pull up his his left lower leg. Client pant leg. GHS #2 stated trea had been open "a s." GHS #2 stated the 's left lower leg covered burths around" and			will review this list onThursday The Residential Nurse will revi this once a week to ensure it hasbeen completed and to ensure additional administrativ oversight. Records oftraining v	s p r. iew re	

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AND PLAN OF CORRECT	IENCIES ΓΙΟΝ	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	l í	JILDING	onstruction  00	(X3) DATE COMPL 10/27/	ETED	
NAME OF PROVIDER O			STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
PREFIX (EAC	H DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
and mid GHS #2 "red, in: indicate the area stated c his skin client #- were av (Medica GHS #2 client #- applied apply a three tir open sk inch (5" gauze p inflame coverin. Client #- size of t the rem docume medicate  On 10/1 was rev 8/2015 did not picking indicate not limi	dle" of of a stated at a state of a st	lient #4's lower leg. lient #4's skin area was and weepy looking" and as going to treat and cover auze bandage. GHS #2 lipicks the area open" on es/measurements of and inflamed skin area for review in the MAR ministration Record). a wet wash cloth wiping skin area. GHS #2 cin Ointment USP 2%, nount to affected area of the area, covered the with a five inch by nine uze pad, and covered the are remaining red ith a roll of gauze beta's entire lower leg. be medication room. No askin area and no size of an inflammation were the time of client #4's mistration.  be 16pm, client #4's record client #4's 1/21/15 ISP, and 12014 Risk Assessment the identified behavior of a skin. Client #4's record gnosis included, but was biabetes Mellitus. Client RSA Plan" and 1/22/15		TAG	administrative oversight. (Appendix M)		DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/27/	ETED			
	F PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	#4 had MRSA a "picking" his sk. Plan" indicated may include: Sn resemble pimple a rash, fever, we general ill feelin Implementation medications as physician and do MARwill encopick at his skin a hygienewill do sores, rashes, sn Integrity Form a techniques to tre Plan and Skin Ir a client specific safeguards and timplement regar problems once a identified.  On 10/16/15 at (Director of Resprovided multip "Medication Information An undated "Messheet indicated opicking at his let lower leg now he warm to the tour	Plan" both indicated client and issues from client #4 in. Client #4's "MRSA" "Signs and Symptoms all red bumps that es, spider bites or boils or bund that won't heal, a g, headache(staff) will administer brescribed by the boument properly on the bourage [client #4] not to and to maintain proper boument any cuts, open all bumps on the Body and use First Aid eat" Client #4's MRSA attegrity Plan did not have protocol for what reatments staff were to reding client #4's skin an open inflamed area was  1:30pm, the DRS idential Services)  It sheets of undated formation for client #4. Edication Information the edication Information the edicated end area that is each and reddened. There inage[Staff] notified on							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	l í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/27/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	call for his familiantibiotic to be gaddition to admifor 10 dayswilleg three times dare three times daily dressing three times and solid training for Information was and 4/17/15. Cli Information was not incorpor protocols/plans, the group home #4's 10/2015 MA undated Medicate incorporated into On 10/15/15 at 9 conducted with the indicated client #4 client specific nut to his MRSA and The RN indicates skin when it itch #4's skin was "reclient #4's left lo according to client #4's left lo according to client specific nut to the protocol skin when it itch #4's left lo according to client #4's left lo according to client specific nut to the protocol skin when it itch #4's left lo according to client specific nut to the protocol skin when it itch #4's left lo according to client #4's left lo according to clien	leg. The doctor on y physician prescribed an given for 10 days. In nistering the antibiotic lalso: cleanse left lower aily with soap and water. tracin and a dressing late of the complete leg mes daily to ensure the late of						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ILTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G496	B. WI	NG	<u> </u>	10/27	
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		2333 WI	ESTDALE CT		
BONA V	ISTA PROGRAMS	NC		KOKOM	IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		es" from client #4's SIB		IAG			DATE
		Sehavior). The RN stated					
		doctor on 10/12/15 and					
		e not healed in 10 days,					
		be referred to the wound					
	clinic." The RN	stated client #4's					
	"MRSA was not	active" and client #4 had					
	a "history of MR	SA." The RN stated "if					
	the area is weep	y, it should be covered"					
	with a dressing.						
	On 10/16/15 at 3	2:45pm, an interview was					
	conducted with	•					
		ices (DRS). The DRS					
		her information was					
	available for rev						
	2. On 10/13/15	at 4:10pm, GHS (Group					
	Home Staff) #1	asked client #8 into the					
	medication roon	n. GHS #1 administered					
		nedications and one					
	_	luocinonide 0.05%					
		fingers three times a day"					
	1	n. GHS #1 indicated					
	_	le Antibiotic Cream,					
		three times a day (for red					
		(n)(at) 8:00am, 4:00pm, vas not available for					
	. / .	At 5:15pm, the agency					
		Nurse) was present in the					
	, -	ng room. The RN					
		ility followed Core					
		ation administration					
		ication administration.					
	1		- 1				I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496		ILDING	NSTRUCTION  00	(X3) DATE COMPL 10/27/	ETED	
	PROVIDER OR SUPPLIER STA PROGRAMS I		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	refilled by the ple cycle. The RN's not available in the administration, the notified by the far was not contacted. Triple Antibiotic being available, client should not medications." A 10/2015 MAR (I Administration I Physician's Order Antibiotic Crean fingers three time and red skin. Clienticated client from the medication on 10/12/15 at 8:00 and 10/13/15 at 4 with the Director (DRS) was condimicated client from the plant of the agent was out of her production of the producti	t 4:20pm, client #8's Medication Record) and 8/2015 or both indicated "Triple in, apply to hands and es a day" for inflamed es a day" for inflamed itent #8's 10/2015 MAR #8 did not receive the 0/12/15 at 4:00pm, pm, 10/13/15 at 8:00am, 4:00pm.  1:45pm, an interview or of Residential Services sucted. The DRS #8's medication should d by the pharmacy. The me facility staff had not acy nurse that client #8						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING  00  COMPLETED  COMPLETED					
15G496 B. WING				10/27/	2015		
	PROVIDER OR SUPPLIER STA PROGRAMS I		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W 0369 Bldg. 00	2004 "Living in medication admi manual, Core Le in the Area of M indicated medical available.  9-3-6(a)  483.460(k)(2) DRUG ADMINIST The system for dru assure that all drug are self-administer without error.  Based on observatinterview, for 1 cadministered (for evening medicate facility failed to without error for Findings include  On 10/13/15 from client #4 was not the group home.  (Group Home St. #4's "Janumet 50"	2:00pm, a review of the the Community" nistration training sson 2: Responsibilities edication Administration ations should be  RATION ag administration must ges, including those that red, are administered ation, record review, and of 5 medications relient #4) during the ion administration, the administer medication client #4.  :  m 3:45pm until 4:25pm, to observed to eat food at At 4:25pm, GHS aff) #1 selected client below, take one tablet by any with meals" for	W 0	369	CorrectiveAction(s): Toensure the system for drug administration, including tho thatself-administer, are administered without error, the following corrective actions who implemented:  1. The Residential Nurse will re-train all staff that work in the home on Bona Vista's Medicati Administration Policy and then complete quarterly retraining of Bona Vista's medication administration policy with all storated that work in the home. Records training will be completed following the training and submitted to the Residential Director for Administrative oversight (Appendix N).	se he vill e ion on	11/26/2015

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AND PLAN	OF CORRECTION		B. W	UILDING	00	COMPL	
		15G496	B. W			10/27/	2015
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DOMAN/	OTA BBOODANO	IN IO			ESTDALE CT		
BONA VI	STA PROGRAMS	INC		KOKON	лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	2.TheResidential Director o		DATE
		is) and administered the			Operations, Residential Director of		
		ient #4. No food was			of Quality Assuranceand Soc		
	1 ^	02pm, client #4 sat down			Services, and the Residential		
	_	m table and consumed			QIDP will review all incident		
	his supper meal.				reports ona daily basis. If the		
					one week period oftime, the to	-	
		3:16pm, client #4's			will meet to discuss interventi		
	10/2015 MAR (				for assistance in the home.		
	Administration Record) and 8/31/2015 "Physician's Order" both indicated "Janumet 50-1000, take one tablet by mouth twice a day with meals" for NIDDM (Non Insulin Dependent				3.TheResidential Nurse will		
					train all staff working in the ho on the MAR, following physicial		
					orders, and special instruction		
					drug administrationsthat are		
					prescribed by the		
	Diabetes Mellitu	ıs).			physician(example taking		
					medications with food) Record fraining will be	ords	
	On 10/15/15 at 1	1:50pm, an interview			completedfollowing the trainir	na	
		Licensed Practical Nurse			and submitted to the Residen	-	
		ucted. The LPN			Director for		
	` ′	hould ensure client #4's			administrativeoversight (Appe	endix	
	physician's order	rs were followed to			O).		
	1 ^ -	t #4's medication with the					
		indicated the facility					
		re A/Core B training for					
		inistration and the					
		and procedure for					
		inistration. The LPN					
		id not follow physician's					
	orders.	id not follow physician's					
	olucis.						
	On 10/16/15 at 2	2:45nm on interview was					
		2:45pm, an interview was					
	conducted with						
		rices (DRS). The DRS					
		#4's medications should					
	be administered	according to physician's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/27/2015
	ROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	orders. The DRS indicated the facility followed Core A/Core B Medication Administration Training.			
	On 10/15/15 at 1:00pm, a review was conducted of the facility's 4/2011 "Medication Administration Handbook" which both indicated each client's physician orders should be followed.  On 10/15/15 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.  9-3-6(a)			
W 0382 Bldg. 00	483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.			
	Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility failed to ensure medication storage closet and medications were kept secured for clients #1, #2, #3, #4, #5, #6, #7, and #8's medication.	W 0382	CorrectiveAction(s): Toensure all drugs and biologicals are locked, in a secured container, exceptwh being prepared for administration, the following corrective actions willbe implemented: 1.TheResidential Nurse will re-train all staff working in the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		î í	JILDING	onstruction  00	(X3) DATE COMPL 10/27/	ETED		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT			
BONA VI	STA PROGRAMS I	NC	KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
IAG	On 10/14/15 from GHS (Group Hoclient #4 to come At 6:55am, GHS medication cabin medication bin fithe medication bin front of client #4 7:10am, client #4 medication at ey From 6:55am unthe medication relocking client #4 the desk, locking and without the staff's eye sight. the room to retri second time was cloth. At 7:10am relocked/secured from on top of the medication cabin cabinet. At 7:25 she had left the result #4's medication failed to secure I medication cabin failed to secure I medication cabin.	m 6:55am until 7:10am, me Staff) #2 requested te to the medication room. S #2 unlocked the net, removed client #4's from the cabinet, and set oin on top of the desk in H. From 6:55am until H sat at the desk with his te level in front of him. Itil 7:10am, GHS #2 left from twice without H's medications laying on g the medication cabinet, medication being within One time GHS #2 left eve gloves and the to retrieve a wet wash m, GHS #2 I client #4's medications me desk into the met and locked the fram, GHS #2 indicated froom twice during client administration and had mis medications and the		IAU	group home on BonaVista's Medication Administration Pol Additionally the Residential Nursewill conduct quarterly retraining on Bona Vista's medication administration policywith all staff working in thome.(Appendix N)		DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		15G496	B. W	ING		10/27/	2015	
NAME OF F	ROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE	•		
BONA VI	STA PROGRAMS I	NC	2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		d when not in the eye						
	_	ity staff. The LPN ility followed the Core						
		g for medication						
	administration.							
		:45pm, an interview was						
	conducted with t							
	Residential Services (DRS). The DRS							
	indicated the facility followed Core  A/Core B Medication Administration							
	Training for medication security.							
	On 10/15/15 at 1	:00pm, a review was						
	conducted of the	•						
		ministration Handbook"						
		ated each client's						
	physician orders	should be followed.						
	On 10/15/15 at 1	:00pm, a record review						
		ndated "Living in the						
	Community" Co	re A/Core B training for						
		nistration indicated in						
	"Core Lesson 3:	-						
		Iedication" indicated the						
		net and medications						
	staff.	ecured by the facility						
	Juii.							
	9-3-6(a)							
	· · ·							
W 0391	483.460(m)(2)(ii)							
	DRUG LABELING							
Bldg. 00	ine facility must re	emove from use drug						

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	FPROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	labels. Based on observent interview, for 1 #8) who had meduring the event administration, the remove from use containers without labels from the secondary in	he facility failed to the the medication but labels and/or illegible supply on 10/13/15.  E:  H:10pm, GHS (Group selected client #8's ocinonide 0.05% cream, three times a day" for GHS #1 applied the cream in her fingers to her right At 4:10pm, GHS #1 ation label was "worn the box and tube could lient #8's name, the, dose, and instructions on's use. GHS #1 capped and replaced the box back inedication supply. At the proup home the the medicated the the facility failed to the medication for the medication supply. At the proup home the the medication for the medication supply. At the proup home the facility failed to the medication for the medication for the medication supply. At the proup home the facility failed to the medication for the medicati	W	0391	CorrectiveAction(s): Toensure that all medication do not have worn, illegible, or missing labels.  1. TheResidential Nurse will retrain all staff working in the home on the procedurefor recording medications and completing the checklist for medications. OnWednesday's the midnight staff will ensure that all medications are labeled correctly as per Bona Vista's Medication Policy and per physician orders, sign a checklindicating completion of this that the Residential Lead DSP will review this list on Thursdays. Residential Nurse will review to on a monthly toensure it has be completed and to ensure additional administrative oversight. Records of training the training and submitted to the Residential Director for administrative oversight (Appendix M)	, hat ask, The his been	11/26/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		A. BUILDING B. WING	G 00	COMPI	COMPLETED 10/27/2015	
	PROVIDER OR SUPPLIER		2333	EET ADDRESS, CITY, STATE, ZIP COD 3 WESTDALE CT KOMO, IN 46902	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPL	LD BE	(X5) COMPLETION DATE
	including: the cli	which could be read ents' name, name of the ge, and directions for the				
	(Medication Adn 8/2015 Physician "Fluocinonide 0.	t #8's 10/2015 MAR ninistration Record) and a's Order both indicated 05% cream, apply to es a day" for itchy red				
	with the Director (DRS) was conditionally was conditionally was a pharmacy that was not worm medication was a The DRS indicates should include the directions for the DRS indicated the Core A/Core B to	8's medication should label on the medication in and client #8's not removed from use. The late client name and medication use. The late facility followed the raining for medication and the facility's policy				
	2004 "Living in to medication admir manual, Core Lea in the Area of Mo	:00pm, a review of the the Community" nistration training sson 2: Responsibilities edication Administration tions should be labeled.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/27/2015		
	PROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	9-3-6(a)					
W 0413 Bldg. 00	483.470(b)(1)(iv) CLIENT BEDROOMS Bedrooms must measure at least 80 square					
	feet in single client bedrooms. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure client #3's single bedroom measured at least 80 square feet.  Findings include:  During observations on 10/13/15 from 3:45pm until 6:05pm and on 10/14/15 from 6:35am until 8:15am, client #3 was observed to be a tall muscular client and in a single bedroom. On 10/13/15 at 4:40pm, client #3 stated his bedroom was "small." Client #3 stated his room was "about a six feet by nine feet." At 5:00pm, client #3 stated he was "6' 7" (six feet seven inches)" tall. Client #3 stated his bedroom was "sometimes a little too little" but he liked having a single bedroom.  On 10/15/15 at 10:00am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated the facility's maintenance person had measured client #3's single	W 0413	CorrectiveAction(s): Toensure client #3's bedroor measures at least 80 square feet for a single clientbedroot the following corrective action will be implemented: 1.Asingle occupancy bedroot measuring 80 square feet for client #3 will be addedto the group home.	om, ons		

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	PROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0436 Bldg. 00	bedroom and stated the bedroom was "72 (seventy-two) square feet." The DRS stated client #3 and #7's shared bedroom was "split" in half to provide clients #3 and #7 their own individual single bedrooms by the maintenance person within the past "7-15 months." The DRS indicated client #3's single bedroom was not 80 square feet of living area.  On 10/14/15 at 11:40am and on 10/15/15 at 10:00am, records for the bedroom measurements were requested and none were available for review.  9-3-7(a)  483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  Based on observation, record review, and interview, for 1 of 3 sampled clients (client #4) with adaptive equipment, facility failed to have client #4's hearing aid available and to have available and encourage client #4 to wear his prescribed eye glasses when opportunities existed.	W 0436	Correctiveaction(s): Toensure that the facility furnishes, maintain in good repair, and teach clientsto us and to make informed choice about the use of dentures, eyeglasses,hearing and othe communications aids, braces and other devices identified bythe interdisciplinary team needed by the client, the	r 5,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G  00	(X3) DATE SURVEY COMPLETED 10/27/2015		
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	DEFICIENCY)	BE COMPLETION DATE	
	3:45pm until 6:0 from 6:35am un at the group hon prescribed heari his prescribed ey  On 10/15/15 at 3 was reviewed. (Individual Supp (Behavior Suppo Assessment indi eye glasses and a hearing aid. Cli objective for clic ear hearing aid a glasses. Client a assessment and a Physical both in ear prescribed he 1/6/15 visual ass #4 wore prescrib  On 10/16/15 at 2 with the Directo (DRS) was cond indicated client a prescribed eye g indicated she wo with staff to dete #4's right hearin	ions on 10/13/15 from 05pm and on 10/14/15 til 8:15am, client #4 was ne did not wear his ng aid and did not wear ye glasses.  8:16pm, client #4's record Client #4's 1/21/15 ISP port Plan), 1/2015 BSP port Plan), and 2014 Risk cated he wore prescribed at right ear prescribed ent #4's ISP indicated an ent #4 to wear his right and his prescribed eye #4's 12/23/14 hearing 4/21/15 History and dicated he wore a right earing aid. Client #4's sessment indicated client		following correctiveaction be implemented."  1.TheResidential Nurse wensure that client #4's hear is workingappropriately and available for use and client prescription eye glassesare available for use.  2.TheResidential House Manager will train all staff win the home on client#4's winisk plan, hearing impairme plan, and goals for all stafft work in the home. Records training will be completed following thetraining and submitted to the Residentia Director for administrative oversight(Appendix P).	vill ing aid #4's vorking sion nt risk hat	

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AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G496	B. WING 10/27/2			2015	
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .			/ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			MO, IN 46902		
			1		T		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110		available for review.		1710			DittE
	illioilliation was	available for feview.					
	0.2.7(a)						
	9-3-7(a)						
W 0455	483.470(I)(1)						
	INFECTION CON	TROL					
Bldg. 00		active program for the					
	•	l, and investigation of					
		municable diseases.	W C	)455	CorrectiveAction(s):		11/26/2015
		ation, record review, and	l w c	1455	Toensure there is an active		11/26/2015
		of 4 sampled clients			program for the prevention,		
	(client #4), the fa				control, andinvestigation of		
	•	each sanitary methods			infection and communicable		
	when opportunit	ies existed for client #4.			diseases.		
	Findings include	<b>:</b> :			1.TheResidential House	kina	
					manager will train all staff worl	King	
	During observation	ion on 10/13/15 from			onhandwashing/Universal		
	3:45pm until 6:0	5pm, client #4 walked			Precautions and Infectious		
	throughout the g	roup home, no			Disease Control. Records		
	bandage/coverin	g of his lower left leg			oftraining will be completed		
	•	nd the red shiny skin area			following the trainings and submitted to theResidential		
		elow client #4's left knee			Director for administrative		
		le covering the left lower			oversight.		
		GHS #1 administered			2.TheResidential Qualified		
	client #4's medic				Intellectual Disabilities		
		ched and rubbed his			Professional (QIDP) will traina staff that work in the home on		
	1				the clients' informal handwash		
		ered shiny red skin area			goals.Records of training will t	•	
		No hand washing was			completed following the training	ng	
		g the medication			and submitted tothe residentia	ıl	
		me client #4 was not			Director for administrative		
	•	n scratching/rubbing the			oversight (Appendix J).		
		pm until 5:50pm, client					
	#4 scratched and	l rubbed his open skin					
					•		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/27/2015	
NAME (	F PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE ESTDALE CT		
BONA	VISTA PROGRAMS	INC			10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	area to left lowe into/out of the laroom, opened/clinside/outside, a observed. At 5:: to set the dining silverware without At 5:50pm, client client to client, hand fed himself hamburger on a without washing 5:50pm until 6:0 observed to benefit to reach unscratch and rub his lower left leg without washing On 10/14/15 fro client #4 was ob home. At 6:55a #4 to pull up his lower leg. Client leg. GHS #2 stated to lower leg covered around" and "ter side and middled GHS #2 stated con "red, inflamed, a indicated she was	r leg. Client #4 walked andry room, television osed doors, went and no handwashing was 50pm, client #4 assisted room table with out washing his hands. In the passed bowls from andled serving spoons, with his hands a bun and french fries this hands. From 105pm, client #4 was all over his chair at the lader his pant hem to his red shiny skin area on the television of the passed food items					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00		(X3) DATE SURVEY  COMPLETED			
15G496		B. W	ING		10/27/	2015		
NAME OF BROWNER OF GURN IED				STREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			2333 WESTDALE CT					
BONA VI	STA PROGRAMS I	NC		KOKOM	1O, IN 46902			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
		'picks the area open" on						
		2 applied "Mupirocin						
		%, apply a small amount						
	to affected area	three times a day" to the						
	area, covered the	e open skin area with a						
	five inch by nine	e inch (5" x 9") gauze						
	pad, and covered	I the gauze pad and the						
	~	flamed skin with a roll of						
	gauze covering of	client #4's entire lower						
	leg. Client #4 left the medication room.							
	On 10/15/15 at 3:16pm, client #4's record							
	was reviewed. Client #4's 1/21/15 ISP							
	(Individual Support Plan), 8/2015 BSP (Behavior Support Plan), and 2014 Risk							
	Assessment did not indicate the identified							
		ing his itchy skin. Client						
	_	RSA (Methicillin						
		lococcus Aureus, a skin						
	infection) Plan" and 1/22/15 "Skin							
	Integrity Plan" both indicated client #4							
	had MRSA and issues from client #4							
	"picking" his skin. Client #4's "MRSA							
	Plan" indicated "Signs and Symptoms							
	may include: Small red bumps that							
	resemble pimples, spider bites or boils or							
	a rash, fever, wo	und that won't heal, a						
	general ill feelin	<b>~</b> :						
	-	(staff) will encourage						
	[client #4] not to pick at his skin and to							
	maintain proper	hygiene"						
	On 10/16/15 at 1:30pm, the DRS							
		idential Services)						
	`	<u>'</u>						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	<u> </u>		COMPL	COMPLETED	
		15G496	B. WING		10/27/2015			
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					ESTDALE CT			
BONA VISTA PROGRAMS INC					1O, IN 46902			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
		le sheets of undated						
	"Medication Info	ormation" for client #4.						
	An undated "Me	edication Information"						
	sheet indicated of	elient #4 "has been						
	picking at his left lower leg. His left							
		as an open area that is						
	1	ch and reddened. There						
		inage[Staff] notified on						
	_							
	call of [client #4's] leg. The doctor on							
	call for his family physician prescribed an antibiotic to be given for 10 days. In							
	_	-						
	addition to administering the antibiotic							
	for 10 dayswill also: cleanse left lower							
	leg three times daily with soap and							
	water"							
		9:25am, an interview was						
	conducted with t	the agency RN. The RN						
	indicated client	#4 should have been						
	taught and encou	araged to wash his hands						
	after touching hi	s open skin areas and						
	before dining. The RN indicated client							
	#4 picked his skin when it itched. The							
	RN stated client #4's skin was "red,							
	bloody, and covered" on client #4's left							
	lower leg. The RN stated according to client #4's "Body Integrity Form" he had							
	1							
	` ′	open" each "about two						
	inches" from SII	` •						
	Behavior). The RN indicated client #4 saw his doctor on 10/12/15 and "if the							
	areas were not h	ealed in 10 days, [client						
	#4] will be referred to the wound clinic."							
	The RN stated client #4's "MRSA was							
	l							

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
15G496					10/27/	/2015		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	£		2333 WESTDALE CT				
BONA VISTA PROGRAMS INC				KOKOMO, IN 46902				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  CO		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DA DEFICIENCY)		DATE	
	not active" and client #4 had a "history of							
		N stated "if the area is						
	weepy. It should	d be covered" with a						
	dressing.							
	On 10/16/15 at 2:45pm, an interview was							
	conducted with the Director of							
	Residential Services (DRS). The DRS							
	indicated no further information was available for review.							
	On 10/16/15 at 1:30pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included							
	washing hands before medication							
	administration, before eating, and after							
	using the restroom.							
	doing the restroo	111.						
	9-3-7(a)							

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